

reviews

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Torture: European Instruments of Torture and Capital Punishment from the Middle Ages to the Present

Herbst International Exhibition Hall, The Presidio, San Francisco
Until 14 October 2001

www.torturamuseum.com

One of the most unsettling things about living in the San Francisco bay area is the proximity to death row. California has 601 inmates condemned to die by lethal injection or gas, and the killings take place at San Quentin jail, just a short ferry ride from the city. It is hard to reconcile the area's enlightened politics—on race, sex, and sexuality—with its inhumane treatment of prisoners.

Aldo Miglioni, the curator of "Torture," a historical exhibition of devices used to inflict suffering and death, wants to remind the people of San Francisco that torture and execution are happening right on their doorstep. The exhibition has the backing of Amnesty International, Human Rights Watch, and other activist groups that are campaigning to outlaw the death penalty.

Short descriptions or historical drawings accompany the mostly medieval instruments on display, showing how they were used. There are iron thumbscrews, head squeezers, stretching racks, and interrogation chairs with

spikes, many of which were used during the Spanish Inquisition. With piped choral music in the background, and fresh flowers next to some of the most disturbing exhibits, the event feels like a funeral.

There is no guiding chronological or thematic order to the exhibition. This has a disorienting effect, which heightens the difficulty we already face in making sense of the inhumanity on display.

Misogyny and homophobia dominate the history of torture as shown here. Breast rippers, for example, dating from 1300-1700, were used to tear the breasts of women condemned for adultery, pregnancy out of wedlock, self induced abortion, and "erotic white magic." The vaginal pear was forced into women's vaginas before being screwed open, and was used against women found guilty of "sexual union with Satan." The rectal pear was used on gay men.

Another theme is the way in which torture is often glorified, sanitised, or even sexualised, by its perpetrators. Many of the woodcuts and prints show torture as a theatrical spectacle. A 19th century print of a nun being flogged shows her breasts exposed, and she has the faint hint of a smile. As the exhibition notes say, the drawing has "an air of sweetness, safety, bloodlessness."

Artistic representations might attempt to erase the brutality and abuse, but they can never be wholly successful, because we have the power of imagination. We can imagine what it must be like, for example, to experience a torture called the "goat's tongue." The victims' legs were tied to a tree, and the soles of their feet were moistened with salt water. A tethered, thirsty goat would then lick their feet until the flesh was worn away. We can also imagine the horror of being forced to ride Jock's Mare, a sharp torture instrument that caused gangrene of the scrotum and rectum.

As you wander from one exhibit to the next, you become increasingly numb and withdrawn. Victims of torture often fall into a deep silence after the torture is over, and perhaps our numbness is a form of empathy. You also console yourself with the knowledge that these are historical artefacts from a bygone era.



CRIMINAL MEDIEVAL MUSEUM, SAN GIMIGNANO

The pear was forced into the vagina or rectum before being screwed open



CRIMINAL MEDIEVAL MUSEUM, SAN GIMIGNANO

The maiden: when closed the screams of its pierced victim were inaudible

And this is where the exhibition fails. In displaying these instruments as relics or curiosities, and focusing on the past and not the present, it buys into a comforting sense that nothing as unspeakable could possibly occur today. Even the publicity for the exhibition plays up a ghoulish fascination with medieval atrocities. But torture is still used to intimidate, punish, or interrogate people in more than half of all countries in the world. While there is, at the end of the exhibition, a small display of modern artists' works about execution, this feels like a token.

You won't find the killings at San Quentin mentioned in "Torture." For that, try a different "exhibition"—the website of the California Department of Corrections (www.cdcr.state.ca.us). It shows photographs of the 10 men who have been executed at the jail since 1978, a year after the state restored the death penalty. It names all those living on death row, over half of whom are African American and Hispanic. This injustice is as frightening as anything from medieval times.

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Cot death confusion: explaining the unexplainable

Ever since solicitor Sally Clark was convicted in November 1999 of murdering two of her children, she has maintained her innocence. In the face of an initially hostile press, Clark's family stuck by her and insisted that the deaths of her two baby boys were cot deaths or instances of sudden infant death syndrome (SIDS). Gradually their campaign gathered momentum (it now has its own website, <http://wol.ra.phy.cam.ac.uk/sallyclark/>), and even when Clark lost her appeal against her conviction, last October, it was clear that this case was not going to go away.

From the start, many people—including prominent doctors—had serious misgivings about the safety of the original verdict, particularly about one piece of evidence from a key prosecution witness, the paediatrician Professor Sir Roy Meadow. These concerns have ensured that the Clark case, and the debate over what we know and don't know about cot death, has remained a media issue.

In the past three months there have been several articles about Clark in which her transformation from media *bête noire* to media cause célèbre, the victim of a major miscarriage of justice, can be seen to be complete. On 6 May the *Sunday Telegraph* ran a detailed article titled "Against the odds," in which it argued that much of the medical evidence brought against Clark was flawed. She was found guilty by a 10:2 majority verdict of murdering her first child, Christopher, in 1996 when he was 11 weeks old, and, just over a year later, her second child, Harry, when he was 11 weeks old. (Clark now has a third son, born before her case came to trial.)

Christopher's death had initially been attributed to a respiratory infection, but after the death of Harry—said by the prosecution to be a victim of shaken baby syndrome—it was claimed that both babies had been subject to abuse.

The chronology of how and when suspicions were aroused and the pathological evidence itself seem complex. Post-trial newspaper reports paint a picture of pathological mayhem, with medical experts disagreeing and changing their opinions. The *Sunday Telegraph* article said: "For long periods in the Chester courtroom, the case consisted of erudite discussion of intra-alveolar haemorrhages, haemosiderin-laden macrophages and other such abstruse medical arcana." As Sally Clark's husband,

Stephen, also a solicitor, told BBC's *Woman's Hour* on 26 July 2001, "It has taken me three years to understand some of the medical evidence."

Later in May there were a range of media reports on the Law Society's decision not to strike Clark off, but to suspend her. This was an unusual decision given that Clark is a convicted murderer and was widely held to indicate deep unease among many in the legal profession about the convictions.

On 15 July in a joint investigation, Radio 5 Live and the *Observer* took as their starting point new research claiming that there was a genetic cause of SIDS, thereby calling into question probably the most famous piece of evidence presented at Clark's trial. The new research was the discovery of a so called cot death gene by researchers at Manchester University in February.

One voice missing from these reports was that of Professor Meadow himself, the man responsible for this famous piece of evidence or, as the *Observer* put it, this "crude aphorism." He had told the trial jury that in an affluent family like that of Sally and Stephen Clark, where both parents were non-smokers, the probability of two babies dying of SIDS was one in 73 million. (Meadow has since said the statistic came from a government report and was not his own.) In a case in which jury members were subjected to several weeks of complex and conflicting medical evidence it is Meadow's soundbite statistic that the Clark campaign and the media have subsequently credited with clinching a conviction. Professor Meadow, no stranger to controversy (he was the first to observe and give a name to Munchausen's syndrome by proxy—see editorial on p 296), acquired a reputation as the man who sent Sally Clark to jail. His statistic was the subject of a *BMJ* editorial, "Conviction by mathematical error?" (*BMJ* 2000;320:2-3), which said that the 1 in 73 million figure was seriously flawed and that the odds on the same family having two cases of cot death were much lower, at 1 in 8500. The *Observer's* 15 July article claimed the gene discovery meant that the odds for a second cot death could be as low as one in four.

The difficulty for anyone trying to make sense of this case is that, by its very definition, cot death is something that remains unexplained. The Foundation for the Study of Infant Deaths says that cot death is "the sudden and unexpected death of a baby for no obvious reason" (www.sids.org.uk/fsid/).

Speaking to the *BMJ* this week, Professor Meadow said he had had concerns about the terms on which he was prepared to join the media debate over the Clark case and over cot death itself. Radio 5 Live and the *Observer* both said they had put a series of questions to him, "but he declined to talk to us." Professor Meadow said he would have been happy to appear on a live debate, but Radio 5 Live, he was told, was not live. He was worried that if his responses were taped and inserted into a documentary programme he would be in danger of being "stitched up."



Convicted by a soundbite statistic? Sally Clark and her husband arrive at court

On 29 July, according to the *Sunday Times*, Meadow "broke his silence." But even here, in an article largely sympathetic to him, the point he had most wanted to get across had been missed, or again, maybe just misunderstood, he told the *BMJ* this week. This point, he said, concerned the importance to the trial of the 1 in 73 million statistic. He said: "There's been a lot of talk from the Clark campaign and the media about the fact that the recurrence of death from SIDS was incorrectly discussed at the trial by me. What the papers have missed is that the reason the court never explored any of this is that no expert in the whole case considered either death to be an example of SIDS. No one on either side deemed either death a cot death." Instead, he said, there were obvious signs of trauma on both children (a fact disputed by some pathologists according to some reports), "so the whole issue of cot death recurring was an irrelevance."

He added: "The media tend to present it as a disease, as if a baby died from SIDS, but all it is is a 'Don't know.' Some medical colleagues use the term as if it's a disease. There's a tremendous amount of confusion."

Why did Meadow think the media is so bent on seeking the "cause" of cot death, and why had he received such a hostile press? "The public is very uncomfortable about the issue of child abuse, and they tend to shoot the messenger. And those of us who write about it and speak about it and point it out, we are unpopular messengers."

And where does this leave Sally Clark? With so much divided opinion about her case, the probability is that whatever you believe about it, you could be wrong, and that sounds worryingly like reasonable doubt.

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"To Improve the Evidence of Medicine": The 18th Century British Origins of a Critical Approach

Ulrich Tröhler

Royal College of Physicians of Edinburgh, £10, pp 147
NB: This title has no ISBN, but is available from the BMJ Bookshop

Knowledge and Practice in English Medicine 1550-1680

Andrew Wear

Cambridge University Press, £16.95, pp 496
ISBN: 0 521 55827 1

Rating: ★★★★★; ★★

To future medical historians, the last decade of the millennium will be perhaps most noteworthy for the remarkable renaissance in articles and books on evidence based medicine. In the first monograph here, Ulrich Tröhler, a distinguished Swiss physician and medical historian, reminds us that evidence based medicine is not a new concept and can be traced back to 18th century British origins.

The title of the book is taken from George Fordyce's *Attempt to Improve the Evidence of Medicine*, published in 1783. This was an example of the new philosophical

school of rational empiricism which set about challenging the 17th century dogmatic rationalism of Francis Bacon and John Locke. Publications in the 18th century calling for a more critical evidence based approach to medicine included *The Improvement of Medicine in London* (1775) by John Lettsom (founder of the Medical Society of London), John Gregory's *Observations on the Duties and Offices of a Physician* (1770), and John Aikin's *Thoughts on Hospitals* (1771).

The 18th century in Britain saw the proliferation of learned societies and journals for the dissemination of ideas encouraging dissent and honest analysis of the successes and failures of medicine. Quantitative analysis of data was pioneered in military hospitals and gradually began to infiltrate the journals. Richard Mead and William Cullen made pioneering studies on fevers. Cheselden at St Thomas's introduced the keeping of accurate records that enabled him to analyse the morbidity and mortality of his lithotomy operation for bladder stones. James Lind used the controlled clinical trial in 1747 to show that fruit juice given

to sailors reduced scurvy. This study put the therapeutic clinical trial on the medical map for future generations.

Professor Tröhler's scholarly monograph is a fascinating study of 18th century medical pioneers who used quantified observations to challenge the dogmas of their time and laid the foundations of today's evidence based medical practice.

Andrew Wear's book covers 16th and 17th century British medical practice, an era which cannot lay much claim to be evidence based in its approach. This monograph attempts to synthesise early British medical practice, setting it in its cultural and social context. This was the era of plague, typhus, malaria, high infant and maternal mortality, and low life expectancy (36 years). Doctors were divided into learned physicians, barber-surgeons, and quacks. Pox or syphilis was ubiquitous and remedies for illnesses were few and often not effective. Infectious diseases rather than chronic degenerative diseases were the order of the day, and the majority of the population lived in poverty and squalor. This was a time of entrenched conservative medical practice with few challenging untested dogmas. Consequently, few major medical advances were made in this period of British medicine.

See *Personal view* on p 349.

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Items reviewed are rated on a 4 star scale
(4=excellent)



WEBSITE
OF THE
WEEK

Testing intelligence Few children escape having to take some form of intelligence test. How highly they score depends on a myriad of factors including birth weight, a finding confirmed by a study in this week's *BMJ* (p 310).

The intelligence quotient (IQ) test is well established as a reliable means of assessing mental ability, and a visit to www.iqtest.com provides information about how the test has been derived and what the scores mean. It is also possible to take an IQ test online and be diverted by a tempting link to "amazing (free) techniques" to improve your score.

Being categorised by your IQ may be threatening. This is acknowledged on the route to self testing, which is littered by protective pre-test counselling about the possible adverse effects of finding out how intelligent you are, and the importance of not overinterpreting the test result. "A high IQ," the visitor is warned, "is not a guarantee that an individual will achieve happiness, maintain sanity, or obtain spiritual growth." Quite so. And a low IQ? "Does not mean that the individual will be unsuccessful financially, emotionally, or morally." And the reassurance does not stop there. "Even traditionally exalted groups, such as physicians, can have individuals who would be measured as having only 'normal' intelligence." Who could dispute that?

Moving on a stone's throw via www.searchtheweb.com, you can click on to sites devoted to emotional intelligence, or EQ, which many judge to be as important a parameter as IQ. Further opportunities for self testing are presented, this time of temperament and self esteem.

When the desire for self knowledge has been sated it is worth checking out www.eiconsortium.org. The consortium aims to aid the advancement of research and practice related to the emotional intelligence of organisations. It is based on the eminently believable premise that self awareness, optimism, and empathy increase job satisfaction and productivity. Several august companies are listed as members, although—and there must be a message here—none appears to be related to health care.

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JULY BESTSELLERS

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PERSONAL VIEW

The burden of evidence

Evidence based medicine has advanced our science and helped doctors move from inconsistent, often unsupported, practices based on our last case and anecdotal experience to more uniform, effective care. Rigorous methodology has facilitated efforts to deliver high quality treatment and improve outcomes for large patient populations. We have elevated the science published in journals and presented at meetings. Elegant randomised controlled clinical trials, meta-analyses, and guidelines have changed the support of our recommendations from "because I said so" towards "because we know so." Cost analyses have provided means to allocate our tightening resources efficiently and allow doctors and health systems to survive in an era of intense financial pressure.

However, in the wake of these achievements, the burden of evidence based medicine may have untoward effects on relations between patients and doctors, on personal satisfaction, and on artistic components of the "art of medicine."

Doctor scientists at all levels have a natural curiosity for "proof" that fosters a healthy scepticism of the latest breakthrough in medicine or technology. Our inquisitive nature and investigative tendencies are fostered early in our medical education and serve us well. We are taught to recheck each laboratory value, to scrutinise written reports, and to furrow our brows at the care delivered by the last provider who saw our patient. This philosophy has helped protect our patients from potentially harmful new drugs, trendy herbal treatments, or medical devices ordered on late night television.

Yet, I fear that our search for certain proof has eroded valuable components of care. Taking time with patients, handholding, explaining, comforting, listening, providing hope, and taking interest in our patients' lives are becoming passé in the evidence based revolution of medicine. These lost arts were the mainstay of practice 100 years ago. Our colleagues of past centuries often used foolhardy, unproved, and, occasionally, outright dangerous measures to combat disease before the availability of antibiotics, antidepressants, and antihypertensives.

However, our predecessors often realised the limitations of their medicine and spent time in activities that we no longer esteem because they are not supported by

We must trust our own knowledge and individual "expert opinion"

evidence in a peer reviewed publication or the Cochrane collaboration. We presume that we are better doctors with all of the new tools of science. But I am not so certain. In some aspects we seem to be deficient. With new yardsticks of evidence based medicine we have quickly abandoned vital aspects of medicine that are the most difficult to teach, to measure, and to explain.

I find myself struggling with existentialist questions of my professional life. If there is no proof that my 30 minute health maintenance visit works should I stop seeing my patients regularly? Should I really schedule them back in three months for a follow up visit? Did the extra five minutes talking

about their most recent family outing and personal interests improve their survival? Will my safety and preventive medicine counselling reduce utilisation and expenditure? Is my routine physical examination of the asymptomatic

patient sensitive and specific? Can I justify my value to my hospital system and to my patients' insurers? Often the evidence based answer to most of these questions is not clear or "incomplete evidence." Somehow in our lust for hard data, these unknown answers have transformed into "no."

If there is no clear and convincing evidence the default mode is to view the practice as worthless. Hospital cuts and denials of payment have used this approach to ruthlessly pare away activities without the impossible, often unattainable burden of proof. We are now "guilty until proved innocent" of practising archaic, inefficient medicine if we cannot justify each minute of our activity.

I believe that the "burden of evidence" is threatening our professionalism, interactions between patients and doctors, and career satisfaction. Certainly, we must strive to develop better outcome measures and qualitative methods to capture the humanistic aspects of healthcare delivery that are challenging to quantify. However, there will undoubtedly be many subtleties of our care that will never be validated by p values. We must continue to embrace this valuable side of our art. A lack of evidence in absence of harm cannot be interpreted as useless or futile. There will often be individual cases and components of our care that we personally deem important and valuable.

In the absence of clear harms or evidence against these practices, we must trust our own knowledge and individual "expert opinion." The values of peace of mind, understanding, and comfort for our patients and ourselves cannot be discounted and discarded in the era of modern evidence based medicine.

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SOUNDINGS

Paging Dr Parris

August. High summer and mid silly season. With parliament in recess, Britain's heavyweight political commentators have gone on holiday and the media have turned to trivia. Newspaper readers, grateful at first, soon tire of pap. They begin to long for autumn, when the journalists will sharpen their knives again.

For medical politicians, however, autumn never comes. One of the delights of being on the General Medical Council or, I daresay, the BMA council is that press scrutiny of individual members is almost non-existent. The institutions themselves are subject to routine criticism, but the doctors who run them are largely ignored—or, worse, treated with respect. Even their presidents are spared the cartoonist's pen.

I have never met Tony Blair and I glimpsed Gordon Brown only once, years ago in the students' union. But I know them as well as I know, say, Prince Charles or President Bush, because they are regularly dissected by well-informed writers. When they face important decisions, their options are discussed, the electorate is informed, and the politicians can gauge public opinion.

The medical electorate, by contrast, relies on glossies produced by its official organisations, or on trade newspapers written by lay people. There is no medical Matthew Parris waspishly observing which medical quangoholics are pompous windbags, or Blair toadies, or Trappist monks, or barking mad. Or, maybe, sensible and constructive.

And yet, at intervals, Britain's doctors—all 0.1 million of them—are sent a list of names, unknown or vaguely familiar, and asked to vote. Without feedback from the fourth estate, democracy is a farce. Some like it that way. Years ago, when the GMC discussed regional representation, a member told me, "We can't have this. Nobody who knows me would vote for me." He was not joking, just stating a fact.

Sadly, "Dr Parris" is pie in the sky. No reader would be willing to pay for a journal devoted to professional politics. And no medical writer would want the job. Parliamentary sketchwriters are already struggling to make Westminster's cloned legislators seem interesting. Medical politicians would be an impossible challenge.

Dr Parris dot com? Perhaps the internet is the answer, but for me the words "heavyweight" and "web" are incompatible.

James Owen Drife professor of obstetrics and gynaecology, Leeds

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email editor@bmj.com